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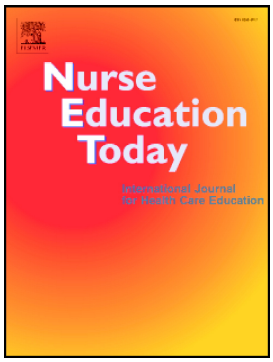

Assessing the educational impact of the dementia champions programme in Scotland: Implications for evaluating professional dementia education

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Assessing the educational impact of the dementia champions programme in Scotland: implications for evaluating professional dementia education

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Abstract

Increasing numbers of people with dementia are living longer with a higher likelihood of requiring hospital care for physical conditions including falls, infections and stroke (Boaden 2016). However, the literature is replete with descriptions of poor care and hospital care experiences that have fallen well below the expectations of people with dementia, their families and friends. Although poor care is unacceptable, it is unsurprising given that dementia education for health and social care professionals is often inadequate and inconsistent. This results in most healthcare staff being ill-equipped and lacking the confidence to work with people living with dementia.

The first of Scotland's National Dementia Strategies committed to "improve the response to dementia in general hospital settings including alternatives to admission and better planning for discharge" (Scottish Government, 2010). The educational response was the commissioning of the Dementia Champions programme. Since 2011, the programme has developed over 800 health and social care professionals working in general hospital and related settings to be change agents in dementia care.

This article will outline the theoretical underpinning of the programme and present pooled results from four cohorts (2014 -2017) (n= 524). A repeated measure design (pre and post programme) was used to measure attitudes towards people with dementia; self-efficacy and knowledge of dementia. The findings suggest that the education had a statistically significant positive effect on all intended outcomes, indicating the potential for practice change. We discuss these findings in relation to the literature, and respond to the calls for high quality evaluation to measure the effectiveness of dementia education, the challenges and potential directions for measuring educational effectiveness and capturing transfer of learning.

Introduction

In 2009, the Alzheimer Society reported unacceptable variations in the quality of care received by people with dementia and their families with some care described as mediocre or neglectful. Bed occupancy rates for people with dementia in the UK are estimated to be as high as 50% and the care experiences of people with dementia in general hospitals continue to fall well below expectations (Boaden, 2016, Elvish et al., 2016). For people with dementia, admission to hospital can result in increased mortality, increased length of stay and an increased likelihood of being discharged to a long-term care setting (Dewing and Dijk, 2014).

The first professional preparation of many health and social care staff to work with and care for people with dementia and their families could be considered inadequate and inconsistent, with many undergraduate programmes having no or limited content on dementia care (Pulsford et al., 2007, Collier et al., 2015). There is a particular lack of dementia education amongst professionals who work outside of mental health, this is an international concern (Hvalič-Touzery et al., 2017). Post-qualifying education has been the predominant strategy to equip staff with knowledge about dementia and improve the quality of dementia care in hospitals across the UK. Following a commitment to improve dementia care in general

hospitals, the Scottish Government funded NHS Education Scotland to commission a collaborative education programme to educate qualified staff to become change agents in dementia care.

There is however a lack of clarity and knowledge about what effective learning looks like and how we can effectively measure the learning that takes place (Elvish et al., 2014). This article adds to this field of knowledge by outlining the theoretical underpinnings and educational context of Scotland's National Dementia Champions programme and illuminating this through providing contemporary findings from the last four cohorts of this programme (2014-17). The aim of doing so is to understand the measurable impact the programme has on participants and to reflect on the extent to which the programme is effective in meeting its aims.

Scotland's National Dementia Champions programme

The key aim of the programme is to enable the Dementia Champions to support and lead change in the workplace, so they can improve the experience, care, treatment and outcomes for people with dementia, their families and carers in general hospitals and at the interface between hospital and community settings.

They are expected to:

- Demonstrate leadership through modelling positive, non-discriminatory, evidenced-based personalised care,
- Work in partnership with family and friends,
- Develop educational activities to disseminate their learning,
- Implement a change management plan with their team with the aim of improving the experience of people with dementia in their care area

The programme is open to professionally qualified health and social care staff. NHS Education Scotland works with Alzheimer Scotland Nurse/AHP consultants, senior NHS staff and Scottish Social Service staff to identify participants with the prerequisites to engage fully in the programme. The criteria for participation includes having the necessary cognitive ability, evidenced by a professional qualification along with self-efficacy and motivation, both characteristics associated with a moderate or strong relationship with learning transfer (Burke and Hutchins, 2007). Further criteria include being IT literate and being in a role where they have opportunity and support to change practice. The programme is educationally aligned to the enhanced level of Promoting Excellence, Scotland's national knowledge and skills framework for health and social care staff working with people with dementia (Scottish Government, 2011).

The theoretical and evidence base of the programme

Human rights, values-based care and an understanding of the social model of disability (Durell, 2014) form the theoretical spine of the programme. All education and interactions are underpinned by the PANEL principles of human rights enshrined in Scotland's Charter of Rights for People with Dementia (Scottish Parliament's Cross Party Group on Alzheimer's, 2009). The PANEL principles are; participation, accountability, non-discrimination and equality, empowerment and legality (Scottish Human Rights Commission, 2018). Commitment to these principles is made visible by the education team modelling exemplary

practice in the participation of people with dementia in the design and delivery of the programme. The learning outcomes were developed following a review of the literature and are discussed in Banks et al., (2014).

The figure below outlines the theoretical and pedagogical approaches used by the education team.

[FIGURE 1]

The theoretical perspective of person-centred care as defined by Kitwood is the conceptual framework of the programme (Kitwood, 1997). Its application to the education of staff working in and around general hospitals facilitates the challenging of stigma and the deficit based definition of and approach to people with dementia that prevails in many hospital settings (Cowdell, 2010, Boaden, 2016, Digby et al., 2017). The education helps participants understand the potential for malignant social psychology; that is, the processes and interactions that depersonalise the person with dementia (Kitwood, 1997). Developing an understanding of person-centred care and the potential for depersonalisation in hospital highlights the interplay and influence of staff on the psychological and physical well-being of people with dementia. It also provides participants with an alternative perspective, one that challenges the medical model of dementia.

The pedagogical methodology combines the approach of adult learning, mentoring by personal tutors and modelling of best practice in attitudes and values. In line with the theory of transformative learning, the facilitative actions by the education team support discourse learning which values the diversity of experience, arguments and perspectives while supporting the participants to access the frame of reference of people with dementia and their friends and family (Mezirow, 2006). Facilitated by direct interactions with people living well with dementia, the participants are supported to critically reflect upon their definitions and framing towards people with dementia. One example that supports active reframing is people with dementia opening the programme on the first day, this is followed by a further three opportunities for participants to experience engagement with people with dementia living well with their diagnosis and their family carers. These opportunities are facilitated in a manner where people with dementia and family members are equals in the learning endeavour and occupy an expert by experience role.

High levels of challenge are underpinned by high levels of support as participants, in their peer groups, are enabled to hear, see and feel the potential experiences of people with dementia when they are using health and social care services. Through learning experiences, targeted towards the cognitive, affective and psychomotor learning domains, awareness of the complexity of the experience of people with dementia is repeatedly illuminated. In addition to increasing knowledge and skills, these learning interventions are targeted directly at the societal stigma mirrored within hospital settings (Digby et al., 2017). This learning is further affirmed with participation in a community activity and the writing of a reflective account of the experience.

Appreciative Inquiry approaches by Cooperrider, Whitney and Stavros (2008) inform the change agent work the participants do in their practice area. The first practice based assignment is to assess what is working well and less well in their care areas. The second practice based assignment participants collaboratively design a change plan to improve care

for people with dementia using improvement science approaches. Thus, the programme design, content and pedagogy takes account of another component that can facilitate effective learning transfer, the intervention design and delivery (Burke and Hutchins, 2007). The third factor of effective learning transfer is work environment influences (Burke and Hutchins, 2007). As outlined above the programme sits within a multi-layered policy and practice response to dementia, participants are encouraged to engage with Scottish Social Service staff and Alzheimer Scotland Nurse/AHP consultants and other colleagues in a dementia related role throughout the programme and work in collaboration with them on their change action plans. Participants also have online access to NHS Education Scotland resources and communities of practice as well as face-to-face input from NHS Education Scotland colleagues.

Methods

Study design

The study adopted a repeated measures design. Participants were asked to complete a range of standardised measures on attitudes to, and knowledge of dementia as well as an indicator of self-reported self-efficacy on the first day and then again eight months later, on the final study day of the programme.

Ethical permission and procedures

The [removed] Ethics Committee gave ethical permission for the study.

Recruitment

Prior to the programme all participants were invited to take part in the study using an introductory letter and participant information sheet. Their pre-programme pack included a consent form and baseline questionnaires. They were invited to complete these prior to the first day. To minimise the influence of the researcher and education team, participants were encouraged to handback the consent forms and questionnaires whether completed or not. This meant those deciding on non-participation are not visually identifiable at the point of data collection. The research team were available to answer questions about the research prior to the first day by phone or email, and in person throughout the first day.

In total, 524 participants enrolled in the programme between 2014 and 2017. Table 1 outlines the occupational background of the participants. Most participants were Health Professionals employed by the NHS, while each cohort had a representation of practitioners from Local Authorities, namely social workers and social care staff. Nurses were the largest group in each cohort, with the majority identifying themselves as Staff Nurses. Others identified as managers, Allied Health Professionals or Nurse Educators. Ninety percent of each cohort were female. Data on age was not collected.

[TABLE 1]

Intervention

The programme was delivered via blended learning; over an eight month period. Each cohort received pre-reading, five face-to-face study days (on five different sites); a half day spent in a community setting, distance learning and the completion of three written assignments. The teaching and learning approaches are outlined above and detailed in Banks et al., (2014). A multi-professional and peer education team, which includes people with dementia and family carers created a learning environment in which the autonomy and responsibility of the students, their individuality and professional backgrounds were recognised.

Upon completion of the programme and successful review of the three assessed assignments, participants were recognised as National Dementia Champions at a national celebratory graduation event.

Data Collection instruments and processes

Participants were provided with the self-complete measures in a printed questionnaire booklet. No personal information about the participants was collected via the questionnaires, other than their occupation and the last three digits of their post-code to allow pre and post questionnaires to be matched. The measures used were:

Approaches to Dementia Questionnaire (ADQ) (Lintern, Woods and Phair, 2000). This scale was selected to reflect the positive person-centred ethos of the Programme. The ADQ is a 19 item scale, based on factor analysis of scores derived from 200 care staff in the UK. There is a total score range of 19-95 and two sub-scores, termed 'Hope' and 'Person-Centred'. Reliability was reasonable with Cronbach's alpha for the Total Score 0.83; for Hope 0.76; and for Person-Centred 0.69, with higher scores reflecting a more positive attitude. Test-retest reliability is also at a reasonable level with 0.76 for the Total Score, the Hope score 0.70, and the Person-Centred 0.69.

Knowledge of Dementia Scale (KIDE) (Elvish, 2014). From cohort six onwards an additional scale measuring knowledge of dementia was introduced. The 16-item KIDE scale was developed from an existing 27-item questionnaire (Fossey et al., 2006). Initial psychometrics were undertaken by the original authors of two studies.(Elvish et al., 2016, Elvish et al., 2014). Results from both studies suggest that the KIDE has good internal consistency and good criterion validity (Cronbach's alpha 0.72; KMO 0.70).

Self Efficacy was measured by a specific scale developed for the programme following the guidance of Bandura (2006). The learning outcomes of the programme were the items in the self-efficacy scale. These were derived from available best evidence and Scottish health and social policy aspirations, providing a programme specific measure of self-efficacy. Participants were asked to rate their ability on the five learning outcomes of the programme on a scale of 0-100 (0 – cannot do at all, 50 = moderately certain can do and 100 = highly certain can do). In measuring the Dementia Champions self-efficacy in relation to the learning outcomes of the programme, we were attempting to gain an understanding of changes in self-efficacy in relation to knowledge, attitude and beliefs about being a change agent and carrying out change agent actions.

Analysis

Raw data for each participant were matched based on the postcode identifiers on the pre and post questionnaires and then inputted into SPSS v22. Data was screened for accuracy and missing data was removed. Descriptive statistics and repeated measures t-tests were carried out on each variable to assess the differences pre and post programme.

Results

Participants:

A number of participants withdrew from the course over the eight-month delivery period for a variety of reasons, although the most commonly cited reason was ill-health. Table 2 below outlines the numbers of participants who completed the course in each year.

[TABLE 2]

Consent was given by all 430 participants, however, not all participants completed both questionnaires. Many measures had missing data and were excluded from the analysis. Exact numbers of participants who completed each measure are reported below with the analysis.

Table 3 shows the mean and standard deviation and associated subscales for the Approaches to Dementia Questionnaire (ADQ) and the Knowledge in Dementia Scale (KIDE).

[TABLE 3]

Table 3 indicates an increase in all the measures at the end of the programme. Paired sample *t*-tests were carried out and found that these increases were statistically significant. The effect sizes calculated indicate the education provides a small-moderate effect on the subscales related to the ADQ and a moderate effect on the KIDE scores. This indicates that the programme has a positive impact on participants' attitudes towards, and knowledge of dementia.

Self-efficacy was measured using a scale based on Bandura (2006). Participants rated their perceived confidence in their ability to achieve the learning outcomes pre and post the programme on a scale of 0-100. Table 4 outlines the mean and standard deviations for perceived self-efficacy for each of the five learning outcomes.

[TABLE 4]

There was a significant increase in perceived self-efficacy for each of the programmes learning outcomes. Calculated effect sizes show that these changes reflect a moderate-large effect. This means that the programme has been consistently successful at increasing the perceived capability the participants have in their ability to make positive changes in their workplace and practice in the way they support people with dementia.

Discussion

The findings indicated that the programme had a measurable impact on participants, regarding their knowledge of dementia, approaches to dementia and confidence in their ability to achieve the learning outcomes. The programme is successful in not only providing health and social care staff with the essential knowledge they need relating to dementia, but

also changing the way participants think about people with dementia. The moderate to large effect sizes on the self-efficacy scale indicate the programme has an impact on the confidence and self-belief participants have in their own ability to work with people with dementia in their care setting. This perceived capability is in stark contrast to previous studies that have highlighted staffs perception that they lack ability, skills and knowledge to work with people with dementia (Cowdell, 2010; Pinkert et al., 2017; Turner et al., 2015). Bandura (2006) asserts that it is perceived capability which has significant influence on optimism, strategic thinking, resilience in the face of barriers to taking action, all essential for staff attempting to drive forward change within their systems of health and social care.

Currently many health professionals are working in environments and systems which are not supportive of people with dementia and it is their positive interpersonal interactions which can have significant impact on the person's hospital stay (Digby et al., 2017). The Theory of Planned Behaviour (Azjen, 2002) highlights the role of attitudes, knowledge and self-efficacy in behaviour change. The findings of this research suggest that the Dementia Champions programme with its emphasis on human rights, values, attitudes, knowledge and skills equips staff with the understanding and positive perceived capability to take a person-centred approach and improving the care of people with dementia in hospitals. This also aligns with previous research which has demonstrated the efficacy of the Scottish Dementia Champions Programme (Banks et al. 2014) as well as other acute care dementia training programmes (Elvish et al., 2014; Galvin et al., 2010; Surr et al., 2016). Additionally, participants exit the taught part of the programme with a bespoke, expert reviewed action plan, which if used, can support the sustainability of their role as a change agent in further improving the care of people with dementia in their practice area.

The intervention design and delivery of the programme have all and more of the features associated with effective dementia educational programmes (Surr and Gates, 2017). The content of the programme also includes components associated with a strong or moderate relationship with learning transfer: learning goals, content relevance, practice and feedback, behavioural modelling and error base examples. However, the programme sits within complex workplace systems where a myriad of factors including organisational, environmental and cultural contexts that influence practice are at play (Surr and Gates, 2017). Arguably, the factor we have the least influence over is a work environment, although we attempt to influence the 'transfer climate' through cues and supports that facilitate participants to apply new learning and skills and provide them with opportunities to share learning and sustain an active change agent role. For example, named Scottish Social Service staff and Alzheimer Scotland Nurse/AHP consultants offer on the ground support, advice, leadership, education and networking opportunities. NHS Education Scotland colleagues provide bespoke educational masterclasses, an online knowledge network of learning resources, and community practice forums. The university teaching team maximise opportunities to offer ad-hoc ongoing encouragement, support and advice.

We know that some champions have gone on to make significant, effective and sustained care and practice improvements. These improvements have been presented at Champions graduation events, the Scottish Dementia Awards and local conferences. The last four graduation events saw fourteen Dementia Champions leading presentations or workshops on the work they have taken forward as part of the programme. This includes: actions to improve the pharmaceutical support for people with dementia in acute care; supporting staff

to work as equal partners with families, friends and carers in the acute setting; the setting up of a Community Care Home Music Network; Delirium prevention; Cognitive Stimulation Therapy groups for members of the community and care home residents; personal music in the emergency department and the development of a bedside vascular access service to reduce multiple Peripheral Venous Cannula (PVC) insertion, reduce pain and distress associated with cannulation and ensure reliable venous access. Others have gone on to masters' study and promoted posts. However, it is beyond the scope of the research carried out as part of the programme to assess the transfer of learning and qualitative impact of these in practice. Many participants are also likely to have made less tangible changes to their care, practice, processes and approaches, to accurately capture these would require ongoing methods of triangulation and longitudinal research.

Strengths and limitations

A key strength of this study is the ability to demonstrate the potential for change in practice through standardised measures. Additionally, presenting four years of data increases sample size and demonstrates that the change is consistent. However, a limitation of the study is the appropriateness of the standardised measures used to evaluate this and similar programmes. While measures such as the Approaches to Dementia Questionnaire (Lintern et al., 2000) and the Knowledge in Dementia Scale (Elvish et al. 2014) provide a basic measure of change within the programme, we would argue that they do not provide extend to capturing practice change resulting in improved care experiences. We would contend that the higher baseline scores and small effect sizes observed in the latter cohorts described here are related to the increased awareness of dementia in both policy and practice contexts. Additionally, the measure of self-efficacy was developed specifically for use in this study and while this is useful for measuring self-efficacy specifically related to the learning outcomes, we acknowledge the limitations in terms of reliability and validity.

Conclusion

The Dementia Champions programme has strong theoretical, pedagogical and ethical underpinnings. Measures such as the Approaches to Dementia Questionnaire (Lintern et al., 2000) and the Knowledge in Dementia Scale (Elvish et al. 2014) provide repeated quantitative measure of change. However, these standardised measures do not provide the complete picture, we would argue while these are indicative of change, they do not capture whether the programme has had a sustained impact on participants practice or the care experience of people with dementia.

The language of contribution rather than impact might be more helpful when attempting to assess change in situations where there are complex factors influencing behaviour (Morton, 2012). Workplace and learning cultures are diffuse and complex and not amenable to linear ideas of change. Changes may occur in the way practitioners feel or interact, some of these changes may be serendipitous, conscious, embodied or attitudinal. Perhaps achieving some conceptual or instrumental shift at the margins rather than effect a straightforward or top down (or even bottom up) change is all we can measure (Macrae et al.,2015). We would

argue that these repeated measures of change illustrate both conceptual and instrumental shift.

Bringing about change also requires challenging the underlying assumptions at an organisational level, this can be particularly difficult in the public sector where cultures are generally hierarchical, focused on internal stability, adherence to rules and procedures and often resistant to flexibility, innovation and openness (Drumm, 2012). Nevertheless, it is important that as dementia practice education progresses; we develop more nuanced and accurate ways of measuring meaningful changes in practice as a result of learning. Concurring with previous studies, (Turner et al., 2015, Houghton et al., 2016) we would like to suggest investing in research that can triangulate pre and post programme data and transfer of learning, so we can begin to articulate the contribution this makes not only to practice but to the care experience of people with dementia.

In these complex layered workplace environments professional staff require not only commitment but managerial and educational support to make changes that result in improvements to the quality of care for people with dementia. We contend that to sustainably improve the quality of care people with dementia receive, human rights based education with a strong theoretical underpinning, supported by all stakeholders with a clear strategic direction is required. Single training days, online programmes and completion of tick box training is inadequate. The gaps in the educational history regarding dementia care of our health and social care staff requires immediate, strategic and integrated action. This action requires joint working between people with dementia and their families, education, researchers, policy makers, professional bodies and individual practitioners. No-one can make the change towards quality care for people with dementia alone.

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Assessing the educational impact of the dementia champions programme in Scotland: implications for evaluating professional dementia education

Table 1 Professional background of Dementia Champion Participants from 2014-2017

	2014	2015	2016	2017	Total
Health Professionals	111	101	111	111	434
Social work/social care	15	12	23	19	69
Other	0	9	0	2	11
Total	126	122	134	132	514

Table 2- Participants who completed Dementia Champions Programme

	2014	**2015**	**2016**	**2017**	**Total**
Registered	126	122	134	132	514
Withdrawn	17	17	30	20	84
Total completed	109	105	104	112	430

Table 3 –Attitudes to Dementia Questionnaire and Knowledge in Dementia Scale Scores

	N	Mean Score (Sd) Pre	Mean Score (Sd) Post	Test statistic	p value	Effect Size (r)
ADQ (total)	274	81.97 (6.51)	85.26 (6.68)	-7.624	.000	.42
ADQ Hope	294	32.13 (3.34)	33.79 (3.45)	-7.376	.000	.39
ADQ Person Centred	317	49.90 (4.34)	51.40 (5.21)	-5.027	.000	.27
KIDE	187	12.83 (3.06)	14.59 (1.14)	-7.460	.000	.48

Table 4 – Descriptive statistics for Perceived Self Efficacy for Dementia Champions Learning Outcomes

		N	Pre	Post	t value	P value	Effect Size (r)
1	**Level of confidence to recognise and respond to the impact of physical, emotional, social, cultural and spiritual environment on the maintenance of rights, choice, identity, dignity and equity for the person with dementia in an acute setting.**	330	58.80 (19.30)	81.02 (12.56)	-20.636	.000	.751
2	**Level of confidence to respond with evidence-based practice to the physical and mental health issues that may affect the individual course of a person's journey before, during and after receiving care in the acute hospital environment**	329	51.20 (21.11)	80.68 (40.57)	-11.905	.000	.549
3	**Level of confidence to recognise and deal with the complexities associated with dementia in the acute setting and other physical health care and community settings that may have legal and ethical implications and act to safeguard the best interests of the person with dementia.**	328	54.33 (20.59)	79.18 (13.87)	-21.498	.000	.765
4	**Level of confidence to apply and evaluate a range of interventions to reduce stress and distress and promote functional capacity and promote ability, strengths and quality of life for the person with dementia, in the acute hospital setting**	328	60.78 (20.10)	83.45 (12.01)	-20.990	.000	.757
5	**Level of confidence to implement leadership and change agent skills and knowledge to enhance and improve the care of the person with dementia in every area of their influence, utilising existing and developing quality improvement systems, sharing good practice with others**	327	50.98 (21.83)	80.63 (12.97)	-24.320	.000	.803

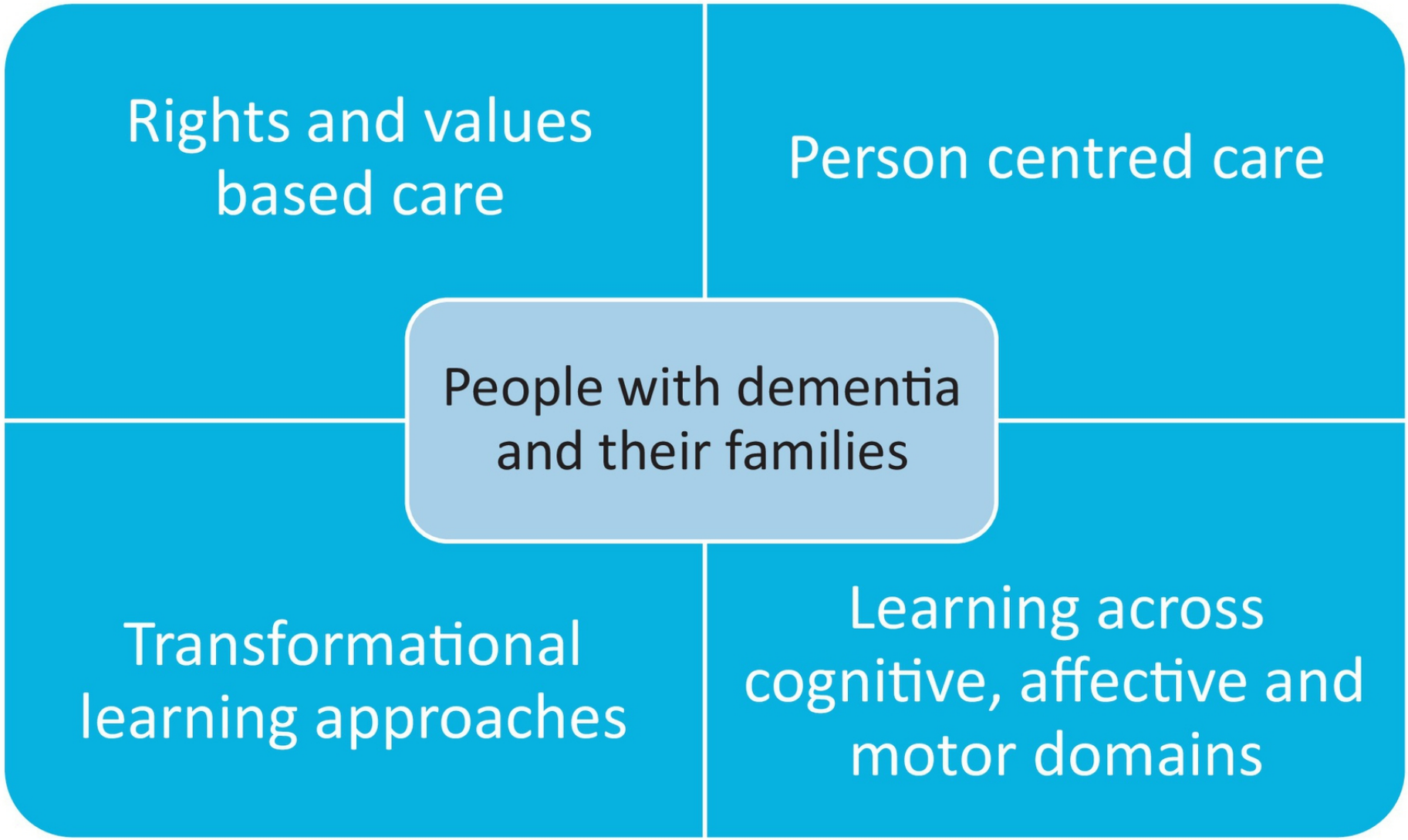
Rights and values based care
Person centred care
People with dementia and their families
Transformational learning approaches
Learning across cognitive, affective and motor domains

Figure 1